State of California
Podiatric Medical Licensure

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Licensing Boards Back Model Law

The Federation of Podiatric Medical Boards, representing the 50 state regulatory agencies, began the 21st Century by developing a model practice act as recommended by the Pew Health Professions Commission.

Two years earlier, in 1998, the podiatric specialty embraced the Pew Commission's two other top recommendations. The Board of Podiatric Medicine (BPM) became the first doctor-licensing board in the country to implement a ***continuing competence program***. The California Podiatric Medical Association (CPMA) supported that advance as well as an increase in BPM's ***public membership***.

Now, BPM and CPMA are both working towards the Pew Commission's third major recommendation: a ***model practice act***. The Pew recommendations are the foundation of the Federation of Podiatric Medical Boards (FPMB) *Model Law*. CPMA is sponsoring legislation to enact it in California. While CPMA amended the bill following give and take with competing specialty groups, it would still update antiquated and discriminatory language. BPM, FPMB, CPMA and the AFL-CIO stand united for this long-overdue reform.

The 1998 Pew Commission report, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, recommended "using the least restrictive practice acts for each profession as models for the rest of the states, unless . . . a given act was enacted on grounds other than evidence of competence." This was based on the vision, expressed in Pew's 1995 report, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, for "a flexible, rational and cost-effective health care system that allows effective working relationships among health care providers."

Based on these principles, the Federation's *Model Law* is designed to:

1. facilitate uniformity among state laws
2. increase license portability across state lines, and
3. improve patient care by allowing licensees to utilize their full scope of training & competence

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"The Mission of the Board of Podiatric Medicine is to ensure protection of consumers through proper use of licensing and enforcement authorities assigned to it by the State Legislature."

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("Model Law"...continued from page 1)

The Joint Legislative Sunset Review Committee (JLSRC) and the Department of Consumer Affairs (DCA), recognizing BPM's role, have commented:

> Although the Department and the Joint Committee do not yet have a position on the *Model Law* being proposed by the Board, any model law that is adopted must embrace the consumer protection mandate inherent in California law and not lessen or erode these standards.
>
> The Board should be commended on its leadership and innovation as it looks at reforming its licensure standards.

The Pew Commission was chaired by former U.S. Senator George Mitchell and included respected leaders from academic, industry, and public interest circles. Edward H. O'Neil, PhD, Director of the UCSF Center for the Health Professions, served as its Executive Director.

George C. Barrett, MD, past president of the Federation of State Medical Boards (with which FPMB works closely) recently said:

> The 1998 Pew Health Professions Commission report, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, is on the shelf but it contains recommendations that should be implemented.

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"Recommendations that Should Be Implemented"

Excerpts from the 1998 Pew Commission report, ***Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation****:*

"These practice acts, often different from state to state, are the source of considerable tension among the professions; the resulting **'turf battles'** clog legislative agendas across the country….These battles are costly and time-consuming for the professions and for the state legislators involved."

"States should enact and implement scopes of practice that are **nationally uniform** for each profession and based on the standards and models developed by the national policy advisory body."

"Some scopes of practice conferred upon licensed occupations and professions are unnecessarily monopolistic, thereby **restricting consumers' access** to other qualified practitioners and increasing the costs of services."

"Health care workforce regulation will best serve the public by. …encouraging a **flexible, rational and cost-effective health care system** which allows effective working relationships among health care providers; and facilitating professional and geographic mobility of competent providers."

"This legislative activity is just one component of 'turf battles,' the apparently inevitable fights between the professions over who can provide what services. **Often lost in the battles between the professions is consumer protection**."

"Narrow scope of practice, restrictive reimbursement standards, and other **legal barriers may limit access to care**."

"While the professions have an interest in minimal restrictions, they also benefit from **the anti-competitive aspects of regulation**. It is always the professions – never the public or consumer advocates – who request regulatory changes to practice acts. . . . Some of the grants of authority have been extremely liberal, resulting in expansive practice acts such as that for physicians; others are extremely restrictive. Requests for changes by one profession are viewed as expansions, encroachments, and infringements by another. From this position, medicine can see every request for regulatory change from any other profession or occupation as a challenge or confrontation."

"A number of professions that provide some or many of the same services as physicians (for example, nurse practitioners, physician assistants, certified nurse midwives, certified nurse specialists, certified registered nurse

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("Should be Implemented"...continued from page 3)

anesthetists and optometrists) have spent considerable amounts of time and money in recent years bolstering requests to change their practice acts to permit them to provide **care that is consistent with their education and training**. Virtually every request has been opposed by organized medicine."

"This fragmented, competitive and adversarial regulatory activity ignores the fact that clinical practice is no longer based on exclusive professional or occupational domains. **Collaborative teams** of health care practitioners who often share some elements of practice authority are more the rule than the exception in today's health care systems."

"Today's practitioners, administrators and consumers are increasingly comfortable with the principle that **if someone is competent to provide a health service safely**, and has met established standards, then he or she should be allowed to provide that care and be reimbursed for it, even if that care was historically delivered by members of another profession."

"The adversarial system for determining practice authority also ignores the **natural evolution of professions**, and individuals within the professions, as they develop their education, training and accreditation standards to meet the changing needs of patients and clients."

"Differences from state to state in practice acts for the health professions **no longer make sense**."

"In a turf battle between two professions, differences in political and financial strength often allows one profession to 'out-gun' the other with factors unrelated to competence and empirical evidence. Practice authority decisions made in this environment do not necessarily answer the question of which professionals are qualified to provide **safe, competent and accessible health care**."

"Regardless of these external factors, appropriate and complete evidence is not always available or easy to find, and relevant standards may change over time. For example, the rationale relied upon by the early advocates for all-inclusive medical acts for physicians at the turn of the century may not be viewed as favorably by today's experts in empirical evidence. Nonetheless, no state practice act today prohibits any licensed physician from performing surgery even though surgical competence may vary tremendously depending on training and specialty."

Federation of Podiatric Medical Boards

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April 9, 2002

The Honorable Carl Washington
California State Assembly
State Capitol Building, Room 2136
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Dear Mr. Washington:

The Federation of Podiatric Medical Boards (FPMB) commends you for introducing **AB 2728.** While addressing antiquated, blatant discrimination against California's 2,000 podiatric medical doctors, it will better utilize their advanced training and competence for the welfare of patients.

As originally introduced, AB 2728 would have implemented the competency-based *Model Law* recently developed by the Federation, with input from licensing officials from the 50 States. We followed the recommendations and principles formulated by the Pew Health Professions Commission, to work towards "a flexible, rational and cost-effective health care system that allows effective working relationships among health care providers."

While disappointed by the opposition stirred by some of our medical colleagues, we respect your political judgement in making amendments at the request of the California Podiatric Medical Association, and remain in support of the stripped-down bill.

As stated in the Pew Commission's Health Care Workforce Regulation Task Force's 1998 report, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* [http://futurehealth.ucsf.edu/publications/index.html]:

"These practice acts, often different from state to state, are the source of considerable tension among the professions; the resulting "turf battles" clog legislative agendas across the country. Caught in the middle of these battles, legislators must decide whether . . . professions currently regulated should be granted expanded practice authority. These battles are costly and time-consuming for the professions and for the state legislators involved. The more critical problem, however, is the decision-making process itself which is distorted by campaign contributions, lobbying efforts and political power struggles. In this environment, practice act decisions may not be based on evidence regarding quality of care and the potential impact on health care costs and access. Such decisions (regarding who can competently provide what types of care) demand a more empirical foundation and a less political venue."

As amended, AB 2728 would simply have three wholly beneficial impacts:

(1) Surgical Assisting:

DPMs in California currently assist MDs in surgery frequently but are the only persons in the operating room who cannot be reimbursed for their services. AB 2728 would maintain the MD's prerogative to ask a DPM to assist in surgery but would allow the DPM to be compensated. The assistance would only occur when the MD desired it and would always be under her or his supervision. This is a matter of economic justice. The alternative is that lesser-trained individuals will assist instead.

(2) Partial Foot Amputations

Since the 1970s, medical staffs in many California health facilities have chosen to delegate diabetic foot care to podiatric surgeons. The Department of Consumer Affairs 1994-95 *Annual Report* commented that the Board of Podiatric Medicine "encouraged the podiatric and orthopaedic associations to work out a compromise on hospital privileging for partial amputations of the foot. Podiatrists are recognized by many hospitals as the experts in care and preservation of the diabetic foot, as well as removal of dead tissue when necessary. But a 1921statute prohibiting amputations by podiatrists is still on the books." It is time to tell all of the parties to negotiate in good faith. The current statute is decades behind the standard of practice in the field.

(3) "No Podiatrist Shall"

The Federation concurs that blatantly discriminatory language does not belong in the law books of California or any other State. We would hold this position regardless of whether it was podiatric medicine or some other specialty being inappropriately singled out.

Sincerely,
Larry I. Shane
Executive Director
Federation of Podiatric Medical Boards

Board of Podiatric Medicine

MODEL LAW ISSUES

Like other doctors, DPMs are restricted by their competence and training through peer review and privileging in health care facilities. Unlike other doctors, they are also restricted by the state license itself to their general area of specialty training. *The Model Law* would retain this distinction, but update California law to reflect many education and training changes over past decades.

The current language of Section 2472 of the Medical Practice Act dates from 1921. It was written to restrict chiropody, the forerunner to podiatric medicine. DPMs often find themselves hamstrung from performing routine procedures that patients and medical staffs want them to perform. Current law sometimes forces procedures to be performed by persons with less medical training.

The Podiatric Scope

Because of their non-restricted license, MDs are licensed to perform many procedures in which they are not competent. They are fully licensed for every medical specialty in addition to their own. This sometimes results in inappropriate care and physician discipline. DPMs, on the other hand, are restricted by the state license itself from performing many procedures in which they are thoroughly trained. Few physicians would advocate specialty licensing. The *Model Law* attempts to make it work better for DPMs.

The 1996 UCSF Center for the Health Profession report, *Podiatry's Role in Primary Care*, commented: "Clearly, their broad medical background can and does assist them in providing care to the foot and leg, as well as identifying other biomedical and behavioral problems their patients may have."

So it is difficult for DPMs to explain to patients and medical staffs, for example, that they can treat a complicated wound on the foot but must refer a minor wound or less serious skin condition, an inch above the ankle, to another doctor.

Surgical Assisting

Patients and other surgeons frequently wish DPMs to assist in non-podiatric procedures because of their surgical skill and trusted doctor-patient relationships. It makes little sense to use an unlicensed technician rather than a DPM to assist in surgery. When podiatrists are credentialed by hospitals to perform complex procedures of the foot and ankle as the *primary* surgeon, there is no logical reason why they should not be permitted to assist an orthopedic surgeon on procedures beyond the ankle as a licensed activity.

Many physicians agree, and utilize DPMs as they consider appropriate together with nurses, physician assistants, and surgical technicians. Under California law, this is legal. The physicians, physician assistants, nurses and unlicensed technicians may all be paid. The DPMs, however, because they are working as unlicensed technicians outside of their scope, often are not.

DPMs still grasp these opportunities to foster cross-specialty collaboration, sharing of expertise, and enhanced patient care. But under State law they are the only ones in the operating room who cannot be compensated.

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The *Model Law* is designed to utilize the DPM's full training for the benefit of the patient—both in the DPM's own independent practice of podiatric medicine, and in MD-supervised assistance in non-podiatric procedures. DPMs could assist MDs ***only*** when the MD desired and ***always*** under the MD's supervision.

The Pew Health Professions Commission recommended that we: "Require interdisciplinary competence in all health professionals. . . . To assure effective and efficient coordination of care, health professionals must work interdependently in carrying out their roles and responsibilities, conveying mutual respect, trust, support and appreciation of each discipline's unique contributions to health care." [*Recreating Health Professional Practice for a New Century*, 1998]

The benefits to California will not be one-sided. In the 1993 *Report on the General Medical and Surgical Components of Podiatric Residency Training in California: A Report to the Medical Board of California and the Board of Podiatric Medicine in California*, Franklin J. Medio, PhD and Thomas L. Nelson, MD reported: "In the teaching hospital, . . . many faculty commented on the teaching contributions made by podiatric residents, both formally and informally. Frequently these are contributions to them and the medical residents and students about topics in podiatry. . . . Repeatedly we heard statements such as . . . 'they teach us things we need to know.'"

"No Podiatrist shall..."

While discriminatory language such as "No podiatrist" was perhaps not uncommon in 1921 when the current law was written, it is an anachronism today. The State Board of Podiatric Medicine respectfully suggests it be rescinded.

"No podiatrist shall do any amputation."

Since at least 1983, the Board of Podiatric Medicine (BPM) has interpreted §2472's prohibition of "amputation" to mean amputation of the entire foot. In many health facilities, and within the American Diabetes Association, DPMs are recognized as experts in diabetic foot care. DPMs specialize in saving feet and in the removal of necrotic tissue, i.e., amputations short of the entire foot as necessary to save the foot and limb. An emotion-laden term, "amputation" nevertheless is often a procedure many medical staffs prefer to delegate to the podiatric surgeon. The law is obsolete and unnecessary. Its literal interpretation does not make medical or common sense. It would disrupt diabetic foot care in California.

Seeking 21st Century Statute

Anne M. Kronenberg, MPA, the Deputy Director of Health for San Francisco, is the Senate's public member appointee to BPM. As the Board's Vice President, she highlighted the Model Law in her 2001 statement to the Joint Legislative Sunset Review Committee:

"Since the last sunset review, we worked with the other 50 state licensing boards, through the Federation of Podiatric Medical Boards (FPMB), to develop a *competency-based* model practice act."

"The Federation was guided by the Pew Health Professions Commission, which in 1998 recommended 'using the least restrictive practice acts for each profession as models for the rest of the states, unless . . . a given act was enacted on grounds other than evidence of competence.'"

"The Pew Taskforce on Health Care Workforce Regulation was following its earlier vision to encourage 'a flexible, rational and cost-effective health care system which allows effective working relationships among health care providers.'"

"The Federation's *Model Law* is based on those principles."

Model Law Links

All links may be accessed from the Board of Podiatric Medicine's website **[http://www.dca.ca.gov/bpm]** or directly:

BPM testimony
http://www.dca.ca.gov/bpm/new/sunset_2001

FPMB Model Law
http://www.fpmb.org/modellaw.html

JLSRC Questions/BPM Answers
http://www.dca.ca.gov/bpm/new/sunset_2001

UCSF Center for the Health Professions
http://futurehealth.ucsf.edu/publications/index.html

See especially *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (Taskforce on Health Care Workforce Regulation, October 1998). http://futurehealth.ucsf.edu/pubs.html

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